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Account Information

Patient Name: _____ Date of Birth _____ SS# _____

PRIMARY PERSON RESPONSIBLE FOR THIS ACCOUNT

Name: _____ Date of Birth: _____ SS# _____

Relationship to patient: _____ Marital Status: Married Divorced Separated Single

Address: _____
Street City/State Zip

How long at this address? _____ Previous location: _____

Home phone: _____ Work Phone: _____ Email: _____

Employer: _____ Occupation: _____ Year of employment: _____

Employer Address: _____
Street City/State Zip

Is the primary party covered by dental insurance? Y N Are there orthodontic benefits we can research for you? Y N

Name of Dental Insurance Company: _____ Group Number: _____

Policy or ID#: _____ Group Name: _____

SECOND PERSON RESPONSIBLE FOR THIS ACCOUNT

Name: _____ Date of Birth _____ SS# _____

Relationship to patient: _____ Marital Status: Married Divorced Separated Single

Address: _____
Street City/State Zip

How long at this address? _____ Previous location: _____

Home phone: _____ Work Phone: _____ Email: _____

Employer: _____ Occupation: _____ Year of employment: _____

Employer Address: _____
Street City/State Zip

Is the primary party covered by dental insurance? Y N Are there orthodontic benefits we can research for you? Y N

Name of Dental Insurance Company: _____ Group Number: _____

Policy or ID#: _____ Group Name: _____

Bringing this completed form to the first appointment or mailing it ahead of time will help you to receive a confirmation of your orthodontic insurance coverage and may expedite setting up an installment payment plan if you want one.